Dr. Gregory Long

CENTRAL ILLINOIS orthodontic associates

(309) 692-2700

7131 N. Knoxville Suite B Peoria
212 N. Davenport Metamora

# PATIENT REGISTRATION

date_____

**PATIENT INFORMATION**

Name_____ Gender_____

Address_____ City_____ State_____ ZIP_____

Home / Cell _____Work_____ Age_____ Birthdate_____

Responsible Party_____ Relationship to Patient_____

Billing address _____ City_____ State_____ ZIP_____

Email_____

**EMERGENCY CONTACT**

Name _____

Relationship to Patient_____ Phone_____

**IF PATIENT IS A MINOR**

Parent _____ Parent_____

Address_____ Address_____

City_____State_____Zip_____ City_____State____Zip_____

Employer_____ Employer_____

**IF PATIENT IS AN ADULT**

Employer_____ Spouse_____

Position_____ Employer_____

**OTHER QUESTIONS**

Has any family member been a patient here before? _____No _____Yes

If so, who? _____

How did you hear about our office? _____

Has any family member worn braces before? _____No _____Yes

If so, who was the orthodontist? _____

**HEALTH INFORMATION**
The following questions are designed to obtain the patient's health history

Does the patient have or has the patient ever had any of the following?

| | | |
|---|---|---|
| ☐ High/Low Blood Pressure | ☐ Diabetes | ☐ Asthma/Hay Fever |
| ☐ Rheumatic Fever | ☐ HIV/Aids | ☐ Epilepsy |
| ☐ Hepatitis/Jaundice | ☐ Fainting Spells/Seizures | ☐ Radiation Therapy |
| ☐ Heart Trouble | ☐ Arthritis | ☐ Stomach Ulcer |

Does the patient require antibiotics prior to treatment? _____No _____Yes ***(please list below)**

_____

Is patient currently under care of physician for an illness/disease? _____No _____Yes***(please list below)**

_____

Has patient ever had trauma to face or teeth? _____No _____Yes***(please list below)**

_____

Does the patient have a bleeding tendency or do wounds heal slowly? _____No _____Yes
Has patient been on Fossamax or any Bisphosphonates (drugs that harden bone)? _____No _____Yes

Is patient **allergic to nickel, latex, any drugs/medications?** _____No _____**Yes, please list**_____

_____

My chief concerns are: _____

_____

_____

Patient's dentist_____

City/State of patient's dentist_____

**PLEASE CHECK ALL STATEMENTS BELOW THAT APPLY TO THE PATIENT**

☐ Patient visits the dentist regularly, at least every _____months.
☐ Patient's last cleaning was in the month of _____.
☐ Patient has not seen the dentist in _____years.
☐ This is patient's first experience with an orthodontist.
☐ The patient has worn braces before.
☐ The patient has seen another orthodontist and would like a second opinion.

**The Teeth**

☐ There are spaces between the teeth the patient does not like.
☐ The teeth are crooked and overlapping
☐ The teeth stick out too far.
☐ The mouth seems too small, not enough room for the teeth.
☐ The teeth are coming in the wrong places.

**The Bite**

☐ The bite is comfortable, and the patient can eat with no difficulties.
☐ The patient feels there is a problem with the bite or has been told there is a problem.
☐ The patient has frequent or chronic pain in their jaws, face, or head.
☐ The patient's jaws click, pop or lock when they open their mouth.
☐ The patient has or has had difficulty in opening and/or closing their jaws.
☐ The patient clenches their teeth during the day or grinds their teeth during the night.
☐ There is a habit I am concerned about (thumb or finger sucking).

**How Much Time are You willing to Commit to Orthodontic Treatment?**

☐ The patient is willing to commit as much time and resources required, even if surgery is needed, to get the best cosmetic and functional results.
☐ The patient wants the best results that can be obtained without any facial/dental surgery.
☐ The patient wants to spend as little time as possible and is willing to accept compromises.

**What Kind of Braces Does the Patient Want?**

☐ The least expensive (silver metal).
☐ The most cosmetic (clear ceramic)
☐ Removable and cosmetic aligners.
☐ I need more information to make a decision.

**How Soon Would You Like to Get Started?**

☐ I would like to get started as soon as possible if it is determined that treatment is necessary.
☐ I want to discuss the findings with my spouse before making a decision to start treatment.
☐ I want to delay treatment as long as possible.

**INSURANCE INFORMATION**

**Primary Insurance**

Policy Holder _____ Birthdate_____/_____/_____

Employer_____

Insurance company_____

Policy/Group#_____

Member ID # or Social_____

**Secondary Insurance**

Policy Holder _____ Birthdate_____/_____/_____

Employer_____

Insurance company_____

Policy/Group#_____

Member ID # or Social_____

**Insurance and Payment Authorization Release**

I authorize the release of any information relating to this claim and understand that I am responsible for all costs of dental treatment.

Responsible Party Signature_____ Date _____/_____/_____

I hereby authorize payment directly to Gregory Long DMD MS PLLC of the group insurance benefits otherwise payable to me.

Responsible Party Signature_____Date_____/_____/_____

# CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

## SECTION A: PATIENT GIVING CONSENT

PARENT NAME _____

PATIENT NAME _____

## SECTION B: TO THE PATIENT — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

**Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

**Contact Person** Tonja – Business Secretary

**Telephone:** (309) 692-2700 **Fax:** (309) 692-5649

**Address:** 7131 N. Knoxville Ave. Suite B. Peoria, IL. 61614

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

X **Signature**

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

X Signature:_____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

X Personal Representative's Name:_____

X Relationship to Patient: _____

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.**

**REVOCATION OF CONSENT**

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.
I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____